Dear Mr. Allenby and Ms Baird

Below are excerpts from the document that defined populations of people with serious mental illness. As I reported in the Monday August 22 meeting, counties from across the state reported to DMH in their initial CSS plans that 95-100% of their clients were defined as "underserved/inappropriately served." Many reported 0% as "fully served." These are the numbers counties submitted in the "Chart A."

As consultant to then-Attorney General and OAC Commissioner Bill Lockyer, I worked in 2005 and 2006 to launch the MHSA and OAC implementation, working closely with DMH personnel. I managed a committee chaired by Commissioners Tricia Wynne (Lockyer designee) and Jerry Doyle of Santa Clara County, and we read all 56-58 CSS plans (300-1,000 pages)—and we sent OAC Comments on the plans to each county, as required by the statute.

Counties that reported 30-40% of clients as "fully served" were questioned as to whether they followed the DMH definitions, and we determined that they had used a variety of other definitions. One of the two commissioners or I represented OAC at the final review meetings in Sacramento, and we found that some mental health directors decided to count everyone with MediCal as "fully served" or used other interpretations independent of the ones provided by DMH.

In these personal interviews and follow-up OAC comments, we concluded that when counties used the DMH definitions, they indeed found that virtually all clients in public mental health system were underserved/inappropriately served. In the first two years of OAC operations, we made every effort to change DMH instructions to counties and ensure that MHSA services would begin to reach those people defined as underserved. We were not successful. Counties continued to spend MHSA revenue on new programs for newly recruited clients instead of improvements to the existing systems of care.

You may know that I am working with other people from around the state to continue to inform state and county executives of MHSA problems of waste, inefficiencies, and misuse of funds intended to raise the standard of service in existing systems—not create a new, independent program for a select few. Today, after seven years and $7 Billion distributions, the state and counties report that 24,000 people are fully served. On the face of it, we believe it warrants investigation. It is frankly painful to review the definition of underserved/inappropriately served and recognize that DMH chose to exclude these consumers in existing county programs from MHSA benefits. Thank you for your consideration.

Sincerely,
Rose King
Rking1@surewest.net

(COVER PAGE OF DOCUMENT—POSTED ON DMH WEBSITE AS LETTER 05-05, AUGUST 1, 2005)

Mental Health Services Act
Community Services and Supports
August 1, 2005
THREE-YEAR PROGRAM AND EXPENDITURE PLAN REQUIREMENTS
Fiscal Years 2005-06, 2006-07, 2007-08

This document lists all requirements for first MHSA plan to be submitted by counties—CSS Requirements August 1, 2005)

(PAGES 15-16 of the document define Unserved, Underserved/Inappropriately Served, and Fully Served populations.

Section II: Analyzing Mental Health Needs in the Community
Direction:
Following identification of community issues, counties must provide an assessment of the mental health needs of county residents and residents of American Indian rancherias or reservations within county boundaries, including adults, older adults and transition age youth who may have or have been diagnosed with serious mental illness, and children, youth and transition age youth who may have or have been diagnosed with serious emotional disorders. The intent is to recognize all those who would qualify for MHSA services, including those who are currently unserved, underserved or fully served, and identify their age and situational characteristics (e.g., homelessness, institutionalization or out-of-home placement, involvement in the criminal or juvenile justice system, etc.).

For purposes of this document the following definitions apply:

Unserved – persons who may have a serious mental illness and children who may have serious emotional disorders, and their families, who are not receiving mental health services. Examples of unserved populations described in the MHSA include older adults with frequent, avoidable emergency room and hospital admissions, adults who are homeless or incarcerated or at risk of homelessness or incarceration, transition age youth exiting the juvenile justice or child welfare systems or experiencing their first episode of major mental illness, children and youth in the juvenile justice system or who are uninsured, and individuals with co-occurring substance use disorders. Frequently, unserved individuals/families are a part of racial ethnic populations that have not had access to mental health programs due to barriers such as poor identification of their needs, provider barriers lacking ethno-culturally competent services, poor engagement and outreach, limited language access, limited access in rural areas and American Indian rancherias or reservations and lack of culturally competent services and programs within existing mental health programs. Some individuals, who should be considered in the priority populations identified in Section III of this document, may have had extremely brief and/or only crisis oriented contact with and/or service from the mental health system and should be considered as unserved.

Underserved/inappropriately served – individuals who have been diagnosed with serious mental illness and children who have been diagnosed with serious emotional disorders, and their families, who are getting some service, but whose services do not provide the necessary opportunities to participate and move forward and pursue their wellness/recovery goals. This category would also include individuals who are so poorly served that they are at risk of situational characteristics such as homelessness, institutionalization, incarceration, out-of home

placement or other serious consequences. Examples of people who are underserved or inappropriately served include older adults who are in institutions because they are not receiving services that would allow them to remain in their own homes, adults who are in Institutions of Mental Disease (IMDs) and Board and Care facilities but not receiving services that would allow them to move to more independent and permanent housing, transition-age youth who are not getting the vocational services they need to become successfully employed, and/or children and youth who may be receiving mental health services in out-of county placements, but do not have the in-home supports needed to allow them to return home with their families. Frequently, underserved individuals/families are a part of racial ethnic populations that have not had access to mental health programs due to barriers such as poor identification of their needs, provider barriers lacking ethno-culturally competent services, poor engagement and outreach, limited language access, limited access in rural areas and American Indian rancherias or reservations and lack of culturally competent services and programs within existing mental health programs.

Fully served – People who have been diagnosed with serious mental illness and children/youth who have been diagnosed with serious emotional disorders and their families, who are receiving mental health services through an individual service plan where both the client and their service provider/coordinator agree that they are getting the services they want and need in order to achieve their wellness/recovery goals. Examples of people who may be fully served include individuals in AB 34 or 2034 programs and children and families receiving Wraparound services within a comprehensive Children's System of Care.

Although counties may also elect to provide some new or expanded services to underserved individuals already receiving some services in their system, DMH expects counties to identify unserved individuals and their families in the priority populations for MHSA funding.

(I put above section in bold because it launched the separate MHSA system. This section directs counties to identify and direct MHSA funds to unserved individuals—this is foundation of the two-tier or "dual system" identified as chief stakeholder complaint in three DMH implementation studies posted on website.

Please Note the definition of "Underserved/Inappropriately Served," the individuals who are essentially excluded from MHSA benefits—and the people who represent at least 90% of public mental health system.

(PAGES 18-19 of the document Includes Chart A, where counties indicate numbers fully served and underserved/inappropriately served, as explained in this section.)

Using the format provided in Chart A, indicate the estimated total number of persons needing MHSA mental health services who are already receiving services, including those currently fully served and those underserved/ inappropriately served, by age group, race ethnicity, and gender. Also provide the total county and poverty population by age group and race ethnicity. (Transition Age Youth may be shown in a separate category or as part of Children and Youth or Adults.)

The DMH's expectation is that counties will identify the number of persons, by age group, race ethnicity, gender and primary language, that may be underserved, including individuals that some might define as inappropriately served such as:
- An older adult with frequent emergency room visits who has not had a comprehensive medical, mental health and social assessment
- An adult living in an IMD or a Board and Care facility because of the lack of supported housing services
- A transitional age youth who does not have a comprehensive plan for transitioning out of foster care, or
- A child/youth living in an out-of-home placement or involved in the juvenile justice system due to lack of access to appropriate community-based services

(Pages 20-21 of the document instruct counties to give priority to unserved populations. Further, if they choose to serve other populations such as "underserved/inappropriately served," counties must specify reasons that these populations are more appropriate. As a practical matter, counties of course did not choose more work and more complications and thus excluded underserved.)

Counties must determine, through their planning process, which populations are the most appropriate to focus on during the first three years. These decisions should be made in the context of the community issues and mental health needs identified in the two previous sections. **Priority should be given to unserved populations**. What follows are recommended initial populations within each age group that are consistent with issues of public concern and the MHSA. **Counties who choose not to select from the initial populations in each age group as described below must specify their reasons for not doing so,** provide clear information as to why the initial populations they identify are more appropriate for this Program and Expenditure Plan, and describe how they are consistent with the purpose and intent of the MHSA.